REVENUE CYCLE CODING STRATEGIES®

Evaluation and Management Coding for 2023

NCOA/SCOS 2023 Joint Conference

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Notices

When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.

The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

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Agenda

- Review Updated E/M Coding Methods
- Review Outpatient & Inpatient Changes
- Review Prolonged Service Changes

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E/M Services

1. New Patient Visits

Updated 2021

2. Established Patient Visits

Updated 2021

3. Consultations

Updated 2023

4. Hospital Care

Updated 2023

5. Team Conferences

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Basic Documentation Principles

Reason for encounter

Relevant history, physical examination findings and diagnostic test results

Assessment, clinical impression or diagnosis

Plan for care

Date and legible identity of provider

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SOAP Format

Subjective	Information obtained from patient; i.e. chief complaint, history of present illness, and review of systems
Objective	Provider's observations; includes the physical examination
Assessment	Provider's impression
Plan	Decisions regarding further evaluation and/ or treatment

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Categories of E/M Services

- Outpatient Office Visits
- Consultations
- Hospital Care
- Other Types

“”

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

-Medicare Claims Processing Manual Chapter 12

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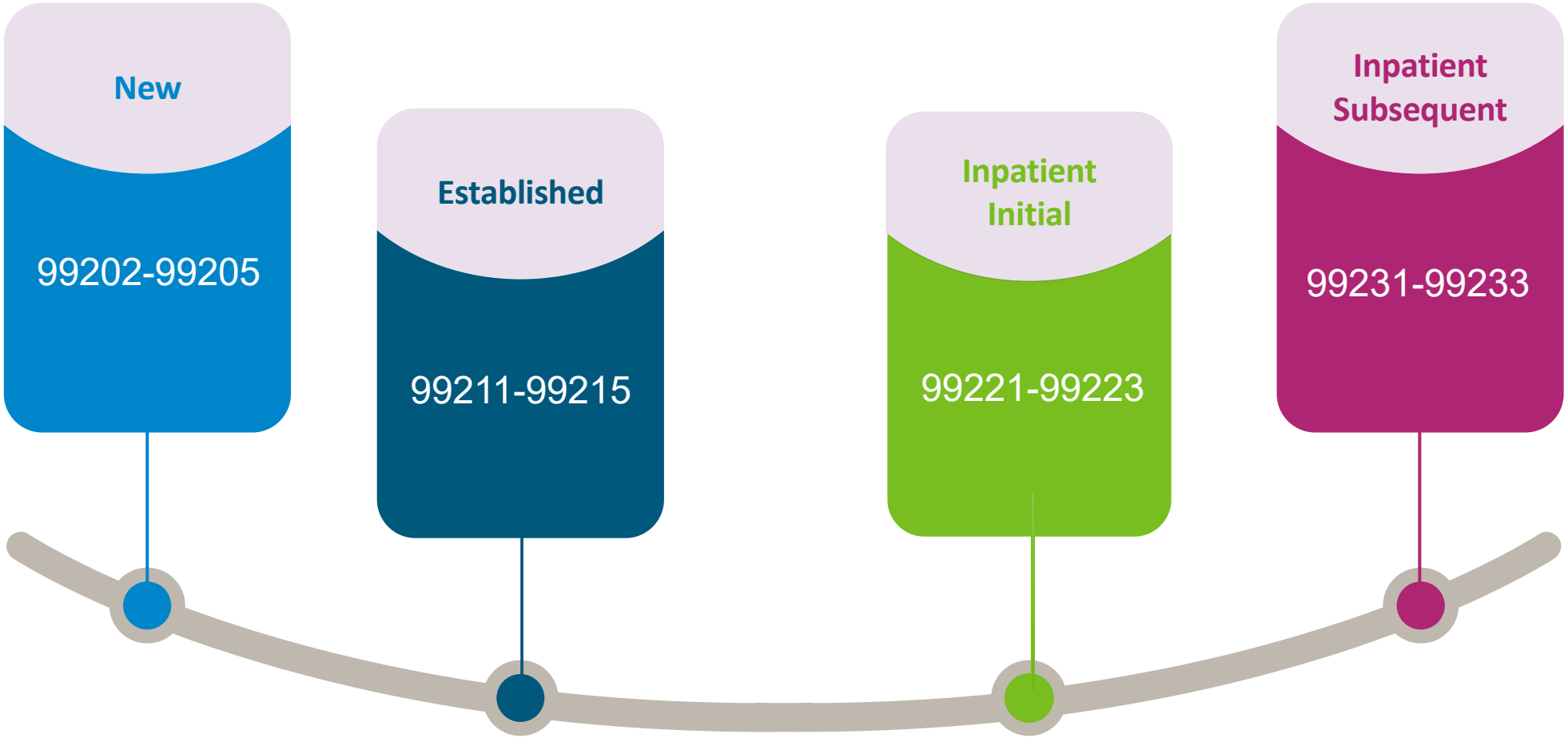
Outpatient & Other Visits



OP/IP Visits

Billing	CPT® Code	Category
	99202, 99203, 99204, 99205	New Patient Visits
	99211, 99212, 99213, 99214, 99215	Established Patient Visits
	99221, 99222, 99223	Initial Hospital Care
	99231, 99232, 99233	Subsequent Hospital Care

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Outpatient
New vs. Established

CMS Medicare Learning Network Evaluation and Management Services Guide

PATIENT TYPE

For purposes of billing for E/M services, patients are identified as either new or established, depending on previous encounters with the provider.

A **new patient** is defined as an individual who has not received any professional services from the physician/non-physician practitioner (NPP) or another physician of the same specialty who belongs to the same group practice within the previous three years.

An **established patient** is an individual who has received professional services from the physician/NPP or another physician of the same specialty who belongs to the same group practice within the previous three years.

Examples

New

Patient completed immunotherapy treatment to the lung in November 2018 and returns in 2023 with a new lung cancer lesion.

Established

Patient treated for lung cancer and returns after 12 months with brain metastasis diagnosis.

CPT® Assistant

Established

Physician on call covering for another physician

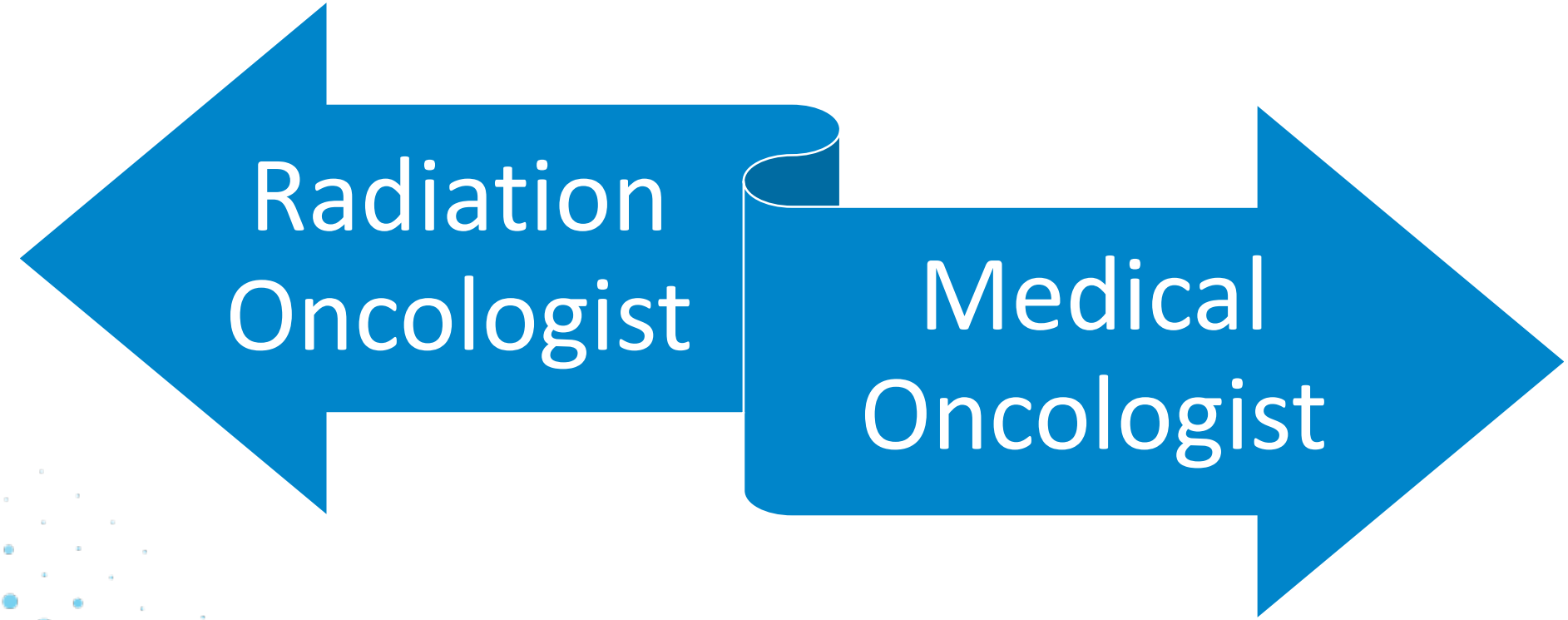
Established

Physician leaves practice and encounters a previous patient seen within the previous 3 years

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

-Medicare Claims Processing Manual

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.



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Initial vs. Subsequent (CMS)

Initial

"An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay."

Subsequent

"A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay."

Code Selection

Time

Medical

Decision Making

The extent of history and physical examination is not an element in code selection

Outpatient / Office - New Patient Visits

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making.	15-29
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	30-44
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	45-59
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	60-74

Outpatient / Office - Established Patient Visits

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	-
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making.	10-19
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	20-29
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	30-39
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	40-54

Inpatient / Observation - Initial Visit

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99221	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straight forward or low** level medical decision making.	40
99222	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	55
99223	Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	75

Inpatient / Observation – Subsequent Visit

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99231	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **straightforward or low** level of medical decision making.	25
99232	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	35
99233	Subsequent hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	50

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MDM Levels

Straightforward

Low

Moderate

High

MDM Scoring

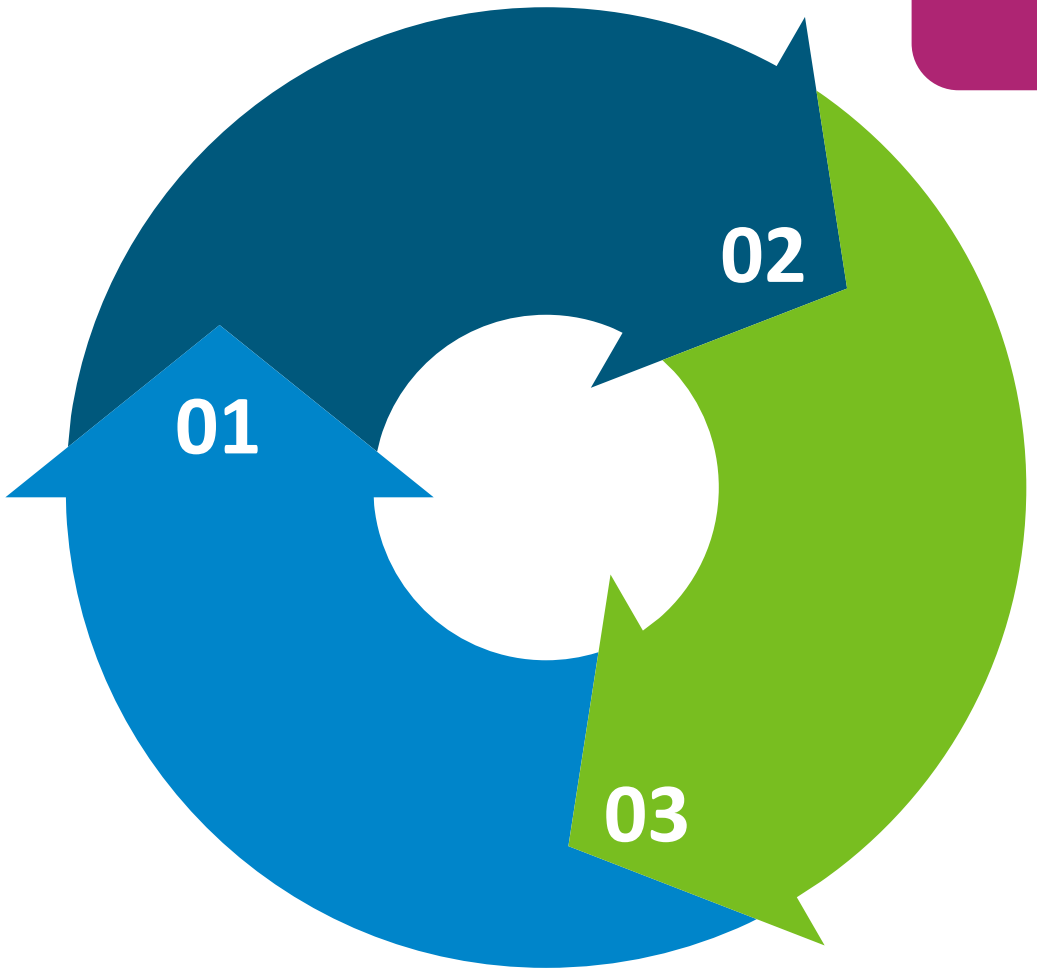
Level of Medical Decision Making is based on 2 out of 3 Element Levels

Data

Amount and/or Complexity of Data to be Reviewed and Analyzed

Problem (s)

Number and Complexity of Problems Addressed at the Encounter



Risk

Risk of Complications and/or Morbidity or Mortality of Patient Management

Element 1: Problem(s)

Problem

- Disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter

Problem Addressed

- Evaluated or treated at the encounter by the physician or QHP reporting the service
- Consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice
- Notation another professional is managing the problem without additional assessment or care coordination documented does not qualify as being ‘addressed’ or managed by the physician or QHP

Problems Addressed Level Options

Minimal

- 1 self limited or minor problem

Low

- 2 or more self-limited or minor problems
- 1 stable chronic illness
- 1 acute, uncomplicated illness or injury

Moderate

- 1 or more chronic illnesses with exacerbation, progression or side effects of treatment
- 2 or more stable chronic illnesses
- 1 undiagnosed new problem with uncertain prognosis
- 1 acute illness with systemic symptoms
- 1 acute complicated injury

High

- 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- 1 acute or chronic illness or injury that poses a threat to life or bodily function

Element 2: Data Reviewed

Tests, documents, orders, or independent historian(s). (Each unique test, order or document is counted to meet a threshold number)

Independent interpretation of tests

Discussion of management or test interpretation with external physician or other qualified healthcare professional or appropriate source

Data Reviewed Level Options

Minimal

- Minimal or none

Limited

- Must meet the requirements of at least 1 of the 2 categories
  - Category 1: Tests and documents (2 elements)
  - Category 2: Assessment requiring independent historian

Moderate

- Must meet the requirements for at least 1 out of 3 categories
  - Category 1: Tests, documents or independent historians (3 elements)
  - Category 2: Independent interpretation of tests
  - Category 3: Discussion of management or test interpretation

Extensive

- Must meet the requirements of at least 2 out of the 3 categories
  - Category 1: Tests, documents, or independent historians (3 elements)
  - Category 2: Independent interpretation of tests
  - Category 3: Discussion of management or test interpretation

Analyzed

Ordered During Encounter	Ordered Outside of Encounter	Recurring Order
Counted for encounter when ordered	Counted for encounter when analyzed	Counted for encounter when new results analyzed

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Tests

Imaging

Lab Work

Psychometric or physiologic data

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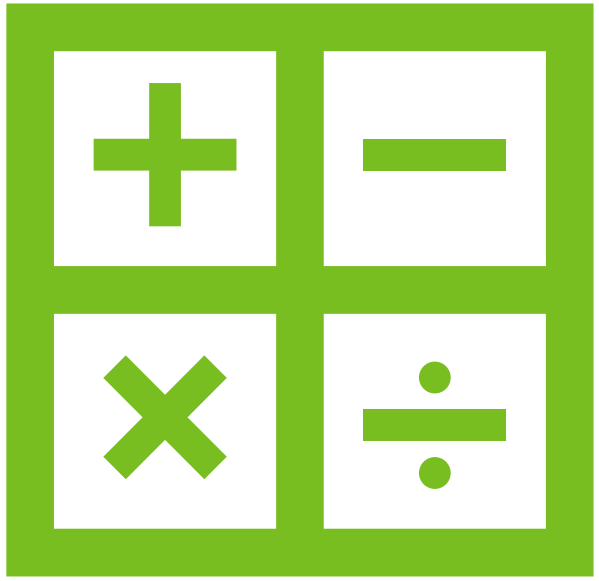
Unique Test

- Defined by CPT® code set
- Multiple results of same unique test equates to “1” test
- Tests with overlapping elements equate to “1” test

  Example: CBC with differential includes hemoglobin, CBC without differential and platelet count

Number of Tests



Each “unique” test may be separately counted

Lab panel is counted as one (1) item

External Physician

Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source

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Discussion

Requires interactive exchange

Not through intermediaries, chart notes or written exchange of progress notes

Not required on date of encounter

Counted when used in decision making of encounter

May be asynchronous

Independent Historian

Person other than the patient (i.e., parent, guardian, spouse, etc.) who provides additional history about the patient

- Cognitive decline
- Age
- Need to confirm factors about the problem(s)

Independent History

Not required to be in person

Must be obtained directly from historian providing information

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Independent Interpretation

Interpretation of a test performed by another physician or qualified healthcare professional

Not separately billable

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Separate Interpretation

Tests that do not require separate interpretation (eg, results only) and are analyzed as part of medical decision making do not count as independent interpretation

May be counted as ordered and reviewed for leveling

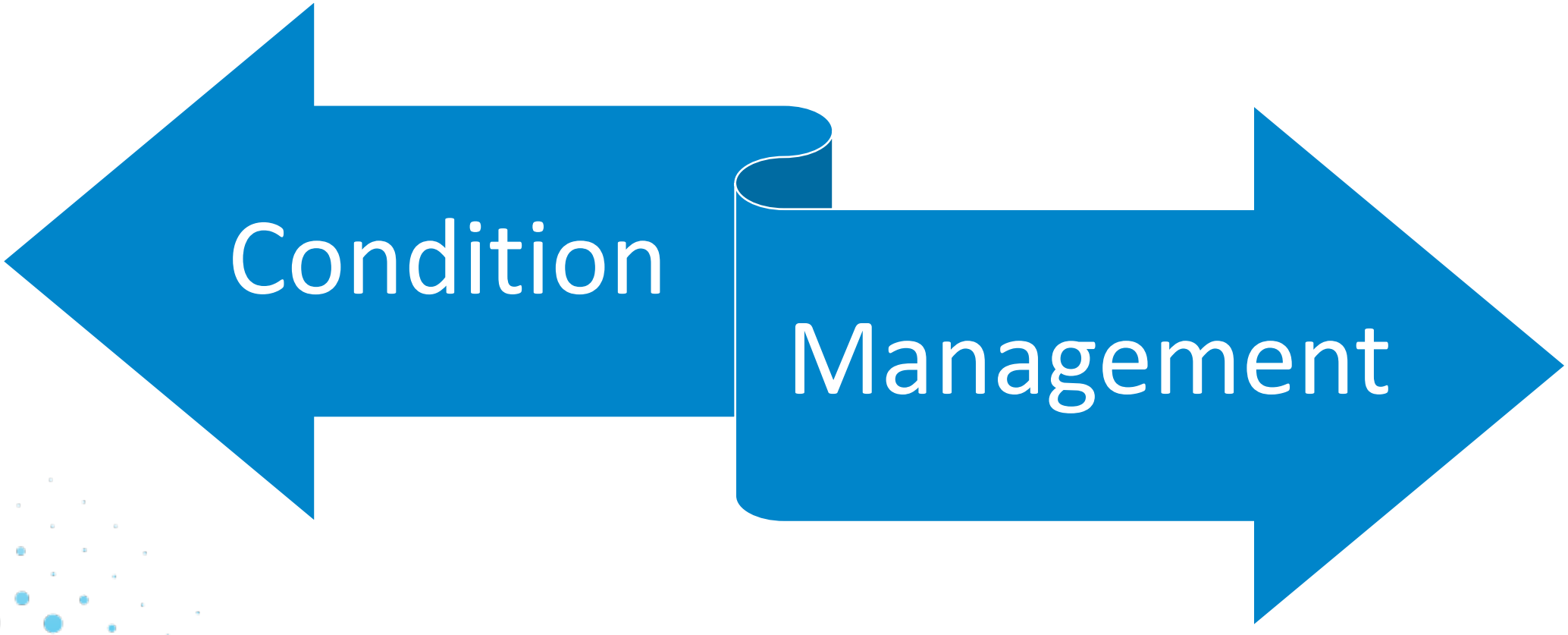
Element 3: Risk

Level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated

Medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization

Includes possible management options selected or considered, but not selected, after shared medical decision making with patient and/or family

The risk of complications and/or morbidity or mortality of the patient management at the encounter is distinct from the risk of the condition.



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Risk Level Options

Minimal

- Minimal risk of morbidity from diagnostic testing or treatment

Low

- Low risk of morbidity from diagnostic testing or treatment

Moderate

- Moderate risk of morbidity from diagnostic testing or treatment
- Examples:
  - Prescription drug management
  - Decision regarding minor surgery with identified risk factors
  - Decision regarding elective major surgery without identified risk factors

High

- High risk of morbidity from diagnostic testing or treatment
- Examples:
  - Drug therapy requiring intensive monitoring for toxicity
  - Decision regarding elective major surgery with identified risk factors
  - Decision regarding hospitalization

Drug Therapy Monitoring

- Drugs that require intensive monitoring are therapeutic agents with the potential to cause serious morbidity or death
- Monitoring performed for assessment of adverse effects and not primarily for assessment of therapeutic efficacy
- Monitoring is generally accepted practice for the agent
- May be long-term or short term
- Monitoring includes lab tests, a physiologic tests or imaging
- Monitoring by history or examination does not qualify

Time Based Reporting

Total time by the billing practitioner on the date of the encounter

Includes face-to-face and non-face-to-face time

Can include time by a qualified healthcare professional

Does not include time spent by clinical staff

Time spent for separately billable services not included

Qualified Healthcare Professional (QHP)

"A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service.

These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service."

Multiple Providers

Physician and other qualified health care professional(s) jointly provide face-to-face and non-face-to-face work for visit

Time personally spent by physician and other qualified health care professional(s) on the date of the encounter can be summed for total time

- AMA instructs: "Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)."

Typical Activities

Preparing to see the patient (eg, review of tests)

Obtaining and/or reviewing separately obtained history

Performing a medically appropriate examination and/or evaluation

Counseling and educating the patient/family/caregiver

Ordering medications, tests, or procedures

Referring and communicating with other health care professionals (when not separately reported)

Documenting clinical information in the electronic or other health record

Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Care coordination (not separately reported)

Not Included

Time is not counted for time spent:

- Performing other services that are reported separately
- Travel
- General teaching, not limited to management of a specific patient

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Total Time Hospital Visits

Initial hospital inpatient or observation care	Total Time (2023)
99221	40 minutes
99222	55 minutes
99223	75 minutes

Subsequent hospital inpatient or observation care	Total Time (2023)
99231	25 minutes
99232	35 minutes
99233	50 minutes

Inpatient Prolonged Service (AMA)

99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time

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CPT Threshold

Initial Inpatient

Total Duration of Initial Inpatient and Observation Care (use code 99223)	Code(s)
Less than 90 minutes	Not reportedly separately
90 minutes	99223 x 1 & 99418 x 1
105 minutes	99223 x 1 & 99418 x 2
120 minutes or more	99223 x 1 & 99418 x 3 or more for each additional 15 minutes

Subsequent Inpatient

Total Duration of Subsequent Inpatient and Observation Care (use code 99233)	Code(s)
Less than 50 minutes	Not reportedly separately
65 minutes	99233 x 1 & 99418 x 1
80 minutes	99233 x 1 & 99418 x 2
95 minutes or more	99233 x 1 & 99418 x 3 or more for each additional 15 minutes

Inpatient Prolonged Service (CMS)

G0316 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

Additional Medicare prolonged codes for 2023 – G0317 nursing facility and G0318 home or residence

Inpatient Prolonged Service (CMS)

Primary E/M Service Prolonged	Prolonged Code	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after

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Consultations

"A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific medical condition.

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service."

- CPT® Manual

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Requirements

Physician or other appropriate source (nonphysician practitioner) must **request** the consultation, and this request must be documented
Physician must perform — or **render** — the consultation
Physician must document the medical necessity for the consultation in the patient medical record, which demonstrates the **reason** for the consultative service
Consultant must prepare a separate written **report** to educate the attending physician (this is generally more than a copy of the patient encounter)
When a transfer of care for the specific condition occurs, the receiving physician should report a new patient visit or established patient visit
If an insurance payer or other source mandates a “confirmatory consultation,” oncologists should submit the appropriate E/M service code appended with modifier 32 (mandated services)

Outpatient Consultations

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99241	Deleted effective 1/1/2023	-
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making.	20
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	30
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	40
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	55

Inpatient Consultations

CPT® Code	Definition	Total Time in Minutes on Date of Encounter
99251	Deleted effective 1/1/2023	-
99252	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making.	35
99253	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	45
99254	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	60
99255	Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	80

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90-Day Follow-Up Period Rad Onc

Medicare Claims Processing Manual, Chapter 13 - Radiology Services and Other Diagnostic Procedures 70.2 - Services Bundled Into Treatment Management Codes (Rev. 1, 10-01-03). A/B MACs (B) do not make separate payment for services rendered by the radiation oncologists or in conjunction with radiation therapy.

The following services are bundled into the treatment management codes:
11920,11921,11922,16000,16010,16015,16020,16025,16030,36425,53670,53675,99211-99215,99238,99281,99282,99283,99284,99285,90780,90781,90847,99050,99052,99054,99058,99071,99090, 99185,99371,99372,99373

- Anesthesia (whatever code billed)
- Care of Infected Skin (whatever code billed)
- Checking of Treatment Charts
- Verification of Dosage, As Needed (whatever code billed)
- Continued Patient Evaluation, Examination, Written Progress Notes, As Needed (whatever code billed)
- Final Physical Examination (whatever code billed)
- Medical Prescription Writing (whatever code billed
- Nutritional Counseling (whatever code billed)
- Pain Management (whatever code billed)
- Review & Revision of Treatment Plan (whatever code billed)
- Routine Medical Management of Unrelated Problem (whatever code billed)
- Special Care of Ostomy (whatever code billed)
- Written Reports, Progress Note (whatever code billed)
- Follow-up Examination and Care for 90 Days After Last Treatment (whatever code billed)

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When to Use a Modifier

- Used to override a PTP edit with a modifier indicator of “1”
- Must be supported and medically necessary

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Documentation for Additional Services

Separate documentation of each service (e.g., E/M and procedure) is recommended so that each service is readily and individually identifiable as such.

Each may be documented separately in progress or other appropriate notes. Separate pages for each service are not required.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intraprocedure, and post-procedure work usually performed each time the procedure is completed. This work shall **not** be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician shall **not** report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure.

-NCCI Policy Manual

Modifier 25

Commonly misused

May be utilized for same diagnosis

- "Above and beyond" usual pre/post procedure service
- Distinct problem or reason for the visit
- Separate documentation to support E/M

Palmetto GBA Resources

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Jurisdiction M Part B

Evaluation and Management

Published 01/09/2023

The CY2022 CMS guidance regarding Split/Shared, Critical Care and other services is located in the following CMS publications:

- MM12550 IOM Manual Updates for Critical Care Evaluation and Management Services
- MM12543 IOM Updates for Critical care, Split/Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants

Palmetto GBA is in the process of updating our web education related to these services based on the CMS guidelines and will notify our provider community through the jurisdictional websites and our Email Updates messaging. Please review the articles above for full details.

https://www.palmettogba.com/palmetto/jmb.nsf/DID/ZXVQYUEC4Z

Thank you for attending!

Questions?